MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Lois Bridges

Annual Inspection Report 2020

PROMOTING
QUALITY, SAFETY
AND HUMAN RIGHTS
IN MENTAL HEALTH

LOIS BRIDGES

Lois Bridges
3 Greenfield Road
Sutton

Date of Publication:
Friday 29 January 2021

ID Number: AC0129

2020 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Acute Adult Mental Health Care

Most Recent Registration Date:
19 January 2019

Conditions Attached:
Yes

Registered Proprietor:
Ms. Melanie Wright

Registered Proprietor Nominee:
N/A

Inspection Team:
Dr Enda Dooley MCRN004155, Lead Inspector
Mary Connellan

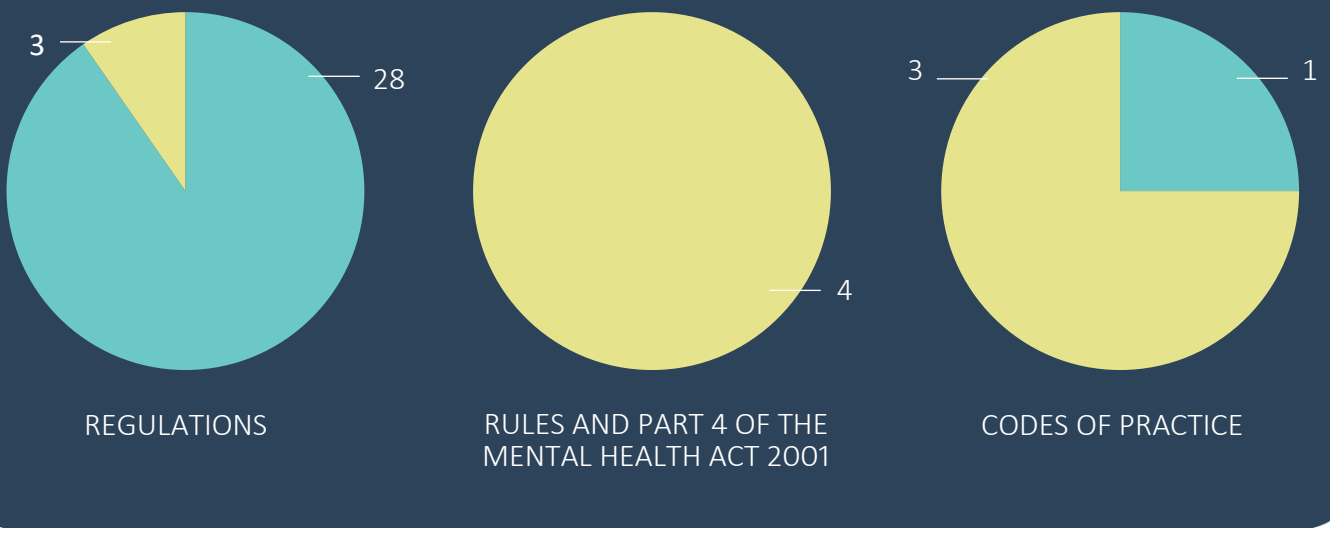
The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

Inspection Date:
14 – 17 July 2020

Previous Inspection Date:
7 – 9 October 2019

Inspection Type:
Announced Annual Inspection

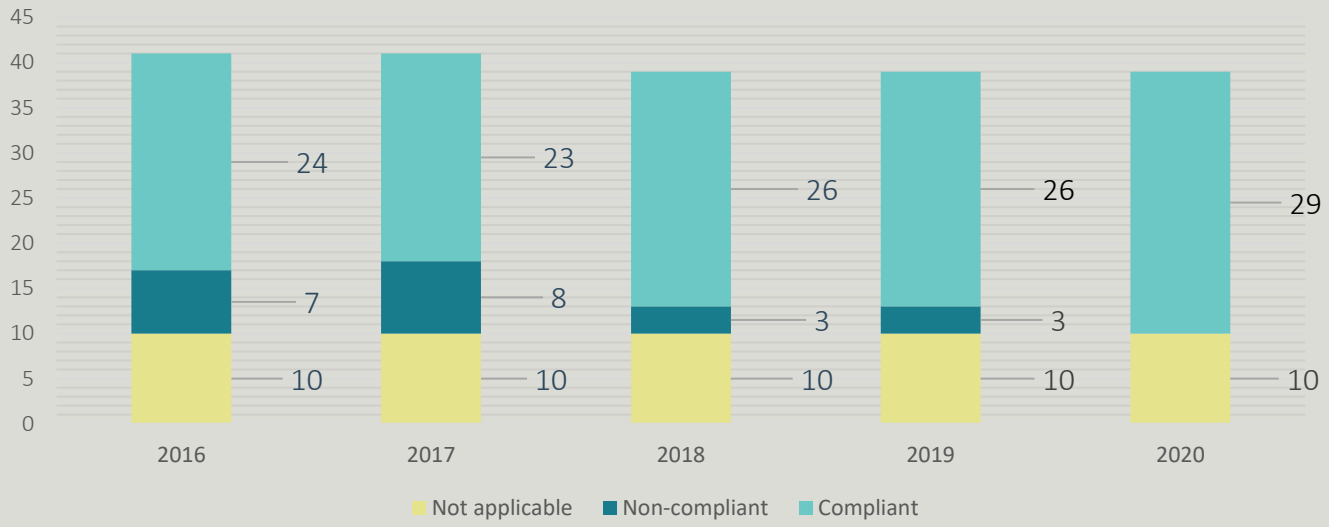
2020 COMPLIANCE RATINGS



RATINGS SUMMARY 2016 – 2020

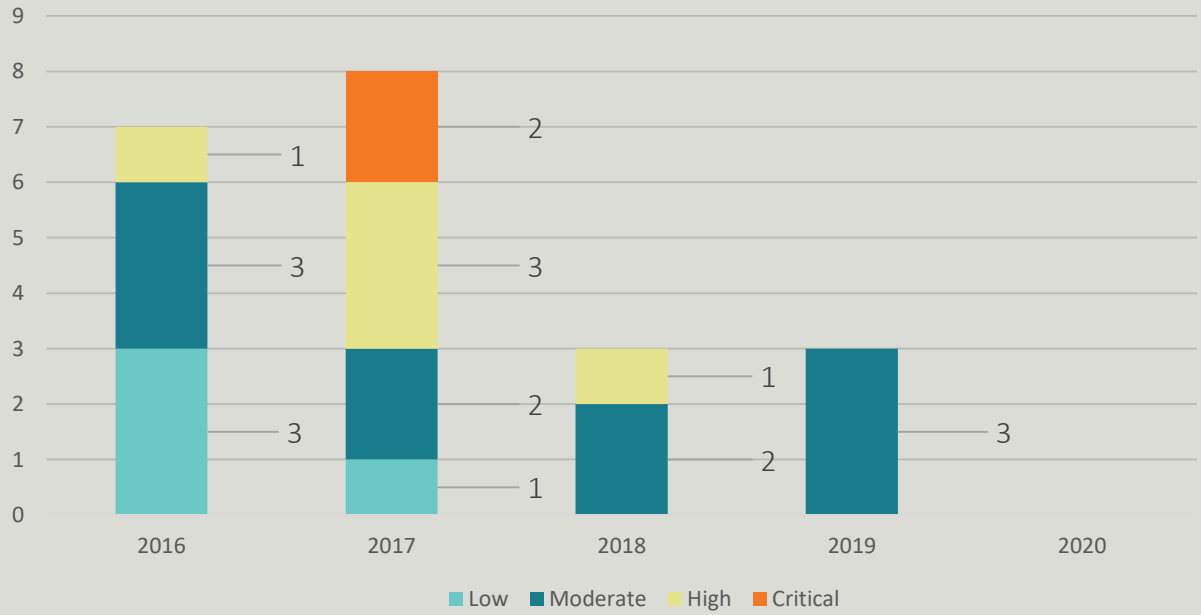
Compliance ratings across all 39 areas of inspection are summarised in the chart below.

CHART 1 – COMPARISON OF OVERALL COMPLIANCE RATINGS 2016 – 2020



Where non-compliance is determined, the risk level of the non-compliance will be assessed. Risk ratings across all non-compliant areas are summarised in the chart below.

CHART 2 – COMPARISON OF OVERALL RISK RATINGS 2016 – 2020



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1.0 Inspector of Mental Health Services – Review of Findings

Inspector of Mental Health Services — Dr Susan Finnerty

This inspection was carried out during the COVID-19 pandemic. Due to public health restrictions, certain activities within approved centres were not able to take place. The inspectors have taken these restrictions into account when assessing compliance with regulations, rules and codes of practice.

In line with Public Health Guidance, the inspectors restricted the amount of time spent in resident areas of the approved centre. Because of this, only compliance with Regulations, Rules and Codes of Practice was assessed, as required by the Mental Health Act 2001, and quality ratings have not been included.

In brief

Lois Bridges was a six bed private in-patient unit, specialising in the treatment of eating disorders. It was located in a suburban dwelling close to the centre of Sutton. Involuntary patients were not admitted to the approved centre. All admissions were planned in advance and the approved centre had an open door policy at all times.

Compliance Summary	2016	2017	2018	2019	2020
% Compliance	77%	74%	90%	90%	100%
Regulations Rated Excellent	2	3	2	6	N/A

Conditions to registration

There were three conditions attached to the registration of this approved centre at the time of inspection.

Condition 1: Pursuant to Section 64(6)(b)(v) of the Mental Health Act 2001 the approved centre must continue to implement and review its protocols and procedures for the admission of residents, including detailed exclusion criteria reflective of the service provided.

Finding on this inspection: The approved centre was not in breach of Condition 1 and the approved centre was compliant with the Code of Practice on Admission, Transfer and Discharge. at the time of inspection.

Condition 2: Pursuant to Section 64(6)(b)(v) of the Mental Health Act 2001 the approved centre must continue to implement and review its protocols and procedures to ensure access to necessary services and specialists, including but not limited to, a gastroenterologist.

Finding on this inspection: The approved centre was not in breach of Condition 2 and the approved centre was compliant with Regulation 19 General Health at the time of inspection.

Condition 3: Pursuant to Section 64(6)(a)(i) of the Mental Health Act 2001 the approved centre is not permitted to admit a high risk resident; with a Body Mass Index (BMI) of less than 13.

Finding on this inspection: The approved centre was not in breach of Condition 3.

Safety in the approved centre

- All health care professionals were trained in Basic Life Support, fire safety, management of violence and aggression, and the Mental Health Act 2001. Staff were trained in Eating Disorders in line with the assessed needs of the resident group profile and of individual residents, as detailed in the staff training plan.
- Ligature anchor points were minimised.
- Food was prepared in a hygienic environment and there were adequate storage, refrigeration, and cooking facilities.
- The ordering, prescribing, storing, and administration of medication was conducted in a safe manner.

Appropriate care and treatment of residents

- Individual care plans (ICPs) were developed by the multi-disciplinary team within seven days and included appropriate resident goals or resources. The ICP was discussed and, where practicable, drawn up with the participation of the resident.
- The therapeutic services and programmes provided by the approved centre were evidence-based, appropriate, and met the assessed needs of the residents, as documented in their individual care plans. Adequate and appropriate resources and facilities were available.
- An Enhanced CBT programme for eating disorders had been introduced.
- The admission, transfer, and discharge of residents was in compliance with the relevant code of practice.
- There was increased access to on-line resources for residents.

Respect for residents' privacy, dignity and autonomy

- The premises was well maintained and was clean throughout.
- All bathrooms could be locked and locks had override functions, where appropriate. Where residents shared a room, bed screening ensured that their privacy was not compromised. All observation panels on doors of bedrooms were fitted with blinds. Noticeboards did not display resident names or other identifiable information and residents were facilitated to make private phone calls.
- There were adequate facilities for residents to meet visitors in private.

Responsiveness to residents' needs

- The approved centre provided access to a wide range of appropriate recreational activities. Activities were available on weekdays and weekends and information of the full programme was displayed on a noticeboard and discussed at weekly community meetings with the residents.
- Information about the approved centre was provided in written format. Information was also available about residents' diagnosis and medication.
- There was a choice of food at mealtimes and meals were attractively presented.
- There was a robust complaints procedure in place.

Governance of the approved centre

- The approved centre was closed in April and May due to COVID-19 restrictions.
- The Management Team, composed of the Registered Proprietor, Clinical Director, and Director of Services, met every six weeks.
- The Management Meeting process considered issues relating to risk and also undertook review of the risk register.
- Regular community meetings were documented, which outlined a process where residents were provided with an opportunity to bring issues of concern to staff attention. The complaints procedure was clearly documented within each room and the centre had a suggestion box centrally located.
- The centre had put in place a variety of processes to allow the resumption of therapeutic activity while observing COVID-19 precautions. Activities outside the house, in the local community, remained curtailed and activities within the house were organised on the basis of social distancing and other COVID-19 precautions.

2.0 Quality Initiatives

The following quality initiatives were identified on this inspection:

1. Extensive refurbishment of the interior of the approved centre.
2. Introduction of enhanced CBT programme for eating disorders.
3. Enhanced administrative and therapeutic staff resources.
4. Increased access to on-line resources for residents.

3.0 Overview of the Approved Centre

3.1 Description of approved centre

Lois Bridges was an independent therapeutic service specialising in the treatment of eating disorders. It was located in a suburban dwelling located close to the centre of the village of Sutton. Prior to the onset of COVID-19, the house was configured to accommodate up to seven residents, including one bedroom shared by two residents. With the onset of COVID-19 precautions, the centre closed temporarily and utilised this time to engage in refurbishment and also to convert the shared bedroom for single use. This resulted in the capacity of the approved centre being reduced to six since it re-opened in mid-May, all being accommodated in single bedroom accommodation.

The centre had adequate living and recreation space which opened to a landscaped rear garden. A separate building within the garden accommodated an office and therapeutic spaces. Supportive interventions were focussed on a psychotherapeutic model and residents had access to a variety of individual and group therapies. The centre was staffed on a 24 hour basis by registered psychiatric nurses and healthcare assistants. All admissions were planned and it was policy not to admit involuntary patients. The centre operated an open door policy.

The resident profile on the first day of inspection was as follows:

Resident Profile	
Number of registered beds	***6***
Total number of residents	**6**
Number of detained patients	0
Number of wards of court	0
Number of children	0
Number of residents in the approved centre for more than 6 months	0
Number of patients on Section 26 leave for more than 2 weeks	0

3.2 Governance

Minutes of recent Management Team meetings were provided to the inspectors. These meetings had occurred at increased frequency due to the various risk factors associated with COVID-19.

During the period the approved centre was closed in April and May the Management Team, composed of the Registered Proprietor, Clinical Director, and Director of Services, had continued to meet every two weeks. More recent these meetings had reverted to every six-weeks. The Management Team meeting

considered a variety of matter pertinent to the safe and efficient operation of the centre. Meetings were minuted and decisions arising documented.

The Management Meeting process considered issue relating to risk and also undertook review of the risk register. Operational, staffing, and clinical risks were documented within the risk register. While maintenance of adequate staff numbers remained a governance item this had not posed significant concern recently.

In addition to the various quality improvements outlined in Section 2 above a governance review, in conjunction with the various therapeutic changes necessitated by COVID-19, had provided an opportunity to improve the range and quality of therapeutic services provided. All residents had a clinical record which was systematically organised. These records documented a comprehensive assessment and clinical monitoring process during the course of treatment.

Residents were involved in the organisation of their individual treatment programmes. Under normal circumstances, it was routine for residents to attend their regular Multi-Disciplinary Team (MDT) meetings. Due to COVID-19 precautions, it had been necessary to alter this so that residents' views were reflected by their keyworker. Regular community meetings were documented which outlined a process where residents were provided with an opportunity to bring issues of concern to staff attention. Complaints procedure was clearly documented within each room and the centre had a suggestion box centrally located.

The centre had put in place a variety of processes to allow the resumption of therapeutic activity while observing COVID-19 precautions. Activities outside the house in the local community remained curtailed and activities within the house were organised on the basis of social distancing and other COVID-19 precautions.

3.3 Reporting on the National Clinical Guidelines

The service reported that it was cognisant of and implemented, where indicated, the National Clinical Guidelines as published by the Department of Health.

4.0 Compliance

4.1 Non-compliant areas on this inspection

There were no areas of non-compliance on this inspection.

4.2 Areas that were not applicable on this inspection

Regulation/Rule/Code of Practice	Details
Regulation 17: Children's Education	As the approved centre did not admit children, this regulation was not applicable.
Regulation 25: Use of Closed Circuit Television	As CCTV was not in use in the approved centre, this regulation was not applicable.
Regulation 30: Mental Health Tribunals	As no Mental Health Tribunals had been held in the approved centre since the last inspection, this regulation was not applicable.
Rules Governing the Use of Electro-Convulsive Therapy	As no involuntary patient had received ECT since the last inspection, this rule was not applicable.
Rules Governing the Use of Seclusion	As the approved centre did not use seclusion, this rule was not applicable.
Rules Governing the Use of Mechanical Means of Bodily Restraint	As no resident had been mechanically restrained since the last inspection, this rule was not applicable.
Part 4 of the Mental Health Act 2001: Consent to Treatment	As there were no patients in the approved centre for more than three months and in continuous receipt of medication at the time of inspection, Part 4 of the Mental Health Act 2001: Consent to Treatment was not applicable.
Code of Practice on the Use of Physical Restraint in Approved Centres	As the approved centre did not use physical restraint, this code of practice was not applicable.
Code of Practice Relating to Admission of Children Under the Mental Health Act 2001	As the approved centre did not admit children, this code of practice was not applicable.
Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients	As the approved centre did not provide an ECT service, this code of practice was not applicable.

5.0 Service-user Experience

The Inspector gives emphasis to the importance of hearing the service users' experience of the approved centre. While previously the inspection team sought to engage with residents face-to-face where possible, this process has changed due to pandemic events and infection control measures. As such, service users' experiences were gathered in the following ways:

- Residents were invited to complete a service user experience questionnaire, which were reviewed by the inspection team in confidence. This was anonymous and used to inform the inspection process.
- Residents could engage with the inspection team over the phone on any matter relating to their care whilst in the approved centre.
- The Irish Advocacy Network (IAN) representative was contacted to obtain residents' feedback about the approved centre.

With the residents' permission, their experience was fed back to the senior management team. The information was used to give a general picture of residents' experience of the approved centre as outlined below.

Two residents requested to meet with the inspectors. It was possible to facilitate this process while maintaining social distancing and other COVID-19 precautions. Both residents spoke positively regarding their experience within the approved centre and regarding their engagement with staff. They were actively involved in their treatment programme and in the Individual Care Plan (ICP) review process. In addition to meeting with two residents all six current residents completed and returned service user questionnaires. No issues of concern was raised.

6.0 Feedback Meeting

A feedback meeting was facilitated prior to the conclusion of the inspection. Due to COVID-19 precautions this meeting was held remotely using Microsoft Teams. This virtual meeting was attended by the inspection team and the following representatives of the service:

- Registered Proprietor
- Clinical Director
- Director of Services
- Administrator

The inspection team outlined the initial findings of the inspection process and provided the opportunity for the service to offer any corrections or clarifications deemed appropriate. The issue of the status of the conditions relating to access to and pre-admission assessment by a gastroenterologist was to be clarified by the Mental Health Commission following recent communications.

7.0 Inspection Findings – Regulations

EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The following regulations are not applicable

Regulation 1: Citation
Regulation 2: Commencement and Regulation
Regulation 3: Definitions

Regulation 4: Identification of Residents

COMPLIANT

The registered proprietor shall make arrangements to ensure that each resident is readily identifiable by staff when receiving medication, health care or other services.

INSPECTION FINDINGS

There was a minimum of two resident identifiers used in the approved centre, including a name and date of birth. These were appropriate to the resident group profile and individual residents' needs. In addition, two resident identifiers were used before administering medications, undertaking medical investigations, and providing other healthcare services. An appropriate resident identifier was used prior to the provision of therapeutic services and programmes.

The approved centre was compliant with this regulation

Regulation 5: Food and Nutrition

COMPLIANT

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.

(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

INSPECTION FINDINGS

Residents were provided with a variety of wholesome and nutritious food, including portions from different food groups, as per the Food Pyramid. Residents had at least two choices for meals. A source of safe, fresh drinking water was available to residents at all times in easily accessible locations in the approved centre. Additionally, in light of the therapeutic nature of the approved centre, all residents had at least weekly nutritional and dietary assessments.

The approved centre was compliant with this regulation

Regulation 6: Food Safety

COMPLIANT

(1) The registered proprietor shall ensure:

(a) the provision of suitable and sufficient catering equipment, crockery and cutlery

(b) the provision of proper facilities for the refrigeration, storage, preparation, cooking and serving of food, and

(c) that a high standard of hygiene is maintained in relation to the storage, preparation and disposal of food and related refuse.

(2) This regulation is without prejudice to:

(a) the provisions of the Health Act 1947 and any regulations made thereunder in respect of food standards (including labelling) and safety;

(b) any regulations made pursuant to the European Communities Act 1972 in respect of food standards (including labelling) and safety; and

(c) the Food Safety Authority of Ireland Act 1998.

INSPECTION FINDINGS

There was suitable and sufficient catering equipment in the approved centre. The approved centre was a domestic style facility catering for six residents and facilities for the refrigeration, storage, preparation, cooking, and serving of food were adequate. Regular cleaning was undertaken, ensuring hygiene was maintained to support food safety requirements. Residents were provided with crockery and cutlery that was suitable and sufficient to address their specific needs.

The approved centre was compliant with this regulation

Regulation 7: Clothing

COMPLIANT

The registered proprietor shall ensure that:

(1) when a resident does not have an adequate supply of their own clothing the resident is provided with an adequate supply of appropriate individualised clothing with due regard to his or her dignity and bodily integrity at all times;

(2) night clothes are not worn by residents during the day, unless specified in a resident's individual care plan.

INSPECTION FINDINGS

An emergency supply of clothing was held in the approved centre, including toiletries. At the time of inspection, all residents had an adequate supply of their own personal clothing, which took into account their preferences, dignity, bodily integrity, and religious and cultural practices. No resident had been required to be nursed in night clothes during daytime hours.

The approved centre was compliant with this regulation

Regulation 8: Residents' Personal Property and Possessions

COMPLIANT

(1) For the purpose of this regulation "personal property and possessions" means the belongings and personal effects that a resident brings into an approved centre; items purchased by or on behalf of a resident during his or her stay in an approved centre; and items and monies received by the resident during his or her stay in an approved centre.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures relating to residents' personal property and possessions.

(3) The registered proprietor shall ensure that a record is maintained of each resident's personal property and possessions and is available to the resident in accordance with the approved centre's written policy.

(4) The registered proprietor shall ensure that records relating to a resident's personal property and possessions are kept separately from the resident's individual care plan.

(5) The registered proprietor shall ensure that each resident retains control of his or her personal property and possessions except under circumstances where this poses a danger to the resident or others as indicated by the resident's individual care plan.

(6) The registered proprietor shall ensure that provision is made for the safe-keeping of all personal property and possessions.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to residents' personal property and possessions, which was last reviewed in April 2019.

Residents were encouraged and supported to manage their own property, unless this posed a danger to the resident or others, as indicated in their ICP and/or in accordance with the approved centre's policy. Secure facilities were provided for the safe-keeping of the resident's monies, valuables, personal property, and possessions, as necessary. If requested, there was a safe for property and monies that the resident did not wish to keep in their room. On admission, the approved centre compiled a detailed property checklist of each resident's personal property and possessions. This checklist was updated on an ongoing basis for possessions that were held on behalf of the resident by the approved centre. The property checklist was kept separately to the resident's individual care plan (ICP) and was available to the resident.

The approved centre was compliant with this regulation

Regulation 9: Recreational Activities

COMPLIANT

The registered proprietor shall ensure that an approved centre, insofar as is practicable, provides access for residents to appropriate recreational activities.

INSPECTION FINDINGS

The approved centre provided access to recreational activities appropriate to the resident group profile: TV, DVD's, Netflix, books, and games. Due to the COVID-19 pandemic and infection control measures, recreational activities outside the approved centre were only slowly being re-introduced at the time of inspection. However, residents could visit local shops, including a coffee shop. The approved centre provided access to recreational activities on weekdays and during the weekend.

The approved centre was compliant with this regulation

Regulation 10: Religion

COMPLIANT

The registered proprietor shall ensure that residents are facilitated, insofar as is reasonably practicable, in the practice of their religion.

INSPECTION FINDINGS

Residents' rights to practice religion were facilitated within the approved centre insofar as practicable.

The approved centre was compliant with this regulation

Regulation 11: Visits

COMPLIANT

(1) The registered proprietor shall ensure that appropriate arrangements are made for residents to receive visitors having regard to the nature and purpose of the visit and the needs of the resident.

(2) The registered proprietor shall ensure that reasonable times are identified during which a resident may receive visits.

(3) The registered proprietor shall take all reasonable steps to ensure the safety of residents and visitors.

(4) The registered proprietor shall ensure that the freedom of a resident to receive visits and the privacy of a resident during visits are respected, in so far as is practicable, unless indicated otherwise in the resident's individual care plan.

(5) The registered proprietor shall ensure that appropriate arrangements and facilities are in place for children visiting a resident.

(6) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for visits.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to visits, which was last reviewed in October 2019.

At the time of inspection, due to COVID-19 related restrictions visitors were permitted into the back room annex, at the back of the garden. Visitors entered from the side of the house and, as such, did not enter into the house itself. Visitors' temperatures were checked and a questionnaire was completed on arrival to the approved centre in line with infection control protocols.

No resident in the approved centre had visiting restrictions at the time of inspection. Overall, the policy in the residence only permitted visitors at certain times as the programmes were running from Monday through to Friday. Additionally, in line with infection control measures, visiting was facilitated in the back garden initially and then in the back annex room and not directly in the main house.

Appropriate steps were taken to ensure the safety of residents and visitors during visits. The visiting area was made suitable for visiting children.

The approved centre was compliant with this regulation

Regulation 12: Communication

COMPLIANT

(1) Subject to subsections (2) and (3), the registered proprietor and the clinical director shall ensure that the resident is free to communicate at all times, having due regard to his or her wellbeing, safety and health.

(2) The clinical director, or a senior member of staff designated by the clinical director, may only examine incoming and outgoing communication if there is reasonable cause to believe that the communication may result in harm to the resident or to others.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on communication.

(4) For the purposes of this regulation "communication" means the use of mail, fax, email, internet, telephone or any device for the purposes of sending or receiving messages or goods.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures relating to communication, which was last reviewed in May 2020.

In accordance with the approved centre's policy, residents had full access to the following, except for meal and therapy times: mail, e-mail, internet, and telephone unless otherwise risk-assessed with due regard to the residents' well-being, safety, and health.

The clinical director or a senior staff member designated by the clinical director only examined incoming and outgoing resident communication if there was reasonable cause to believe the communication may result in harm to the resident or others.

The approved centre was compliant with this regulation

Regulation 13: Searches

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and procedures on the searching of a resident, his or her belongings and the environment in which he or she is accommodated.

(2) The registered proprietor shall ensure that searches are only carried out for the purpose of creating and maintaining a safe and therapeutic environment for the residents and staff of the approved centre.

(3) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for carrying out searches with the consent of a resident and carrying out searches in the absence of consent.

(4) Without prejudice to subsection (3) the registered proprietor shall ensure that the consent of the resident is always sought.

(5) The registered proprietor shall ensure that residents and staff are aware of the policy and procedures on searching.

(6) The registered proprietor shall ensure that there is be a minimum of two appropriately qualified staff in attendance at all times when searches are being conducted.

(7) The registered proprietor shall ensure that all searches are undertaken with due regard to the resident's dignity, privacy and gender.

(8) The registered proprietor shall ensure that the resident being searched is informed of what is happening and why.

(9) The registered proprietor shall ensure that a written record of every search is made, which includes the reason for the search.

(10) The registered proprietor shall ensure that the approved centre has written operational policies and procedures in relation to the finding of illicit substances.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the conducting of searches, which was last reviewed in April 2019. It included all requirements related to:

- The management and application of searches of a resident, his or her belongings, and the environment in which he or she is accommodated.
- The consent requirements of a resident regarding searches.
- The process for conducting searches in the absence of consent.
- The process for the finding of illicit substances during a search.

Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the searching processes, as set out in the policy. A log of searches was maintained. Each search record had been systematically reviewed to ensure that the requirements of the regulation had been complied with. Documented analysis had been completed to identify ways of improving search processes. A review of the search log and interview with staff member indicated that no searches had been implemented since the last inspection.

The approved centre was compliant with this regulation

Regulation 14: Care of the Dying

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written operational policies and protocols for care of residents who are dying.

(2) The registered proprietor shall ensure that when a resident is dying:

(a) appropriate care and comfort are given to a resident to address his or her physical, emotional, psychological and spiritual needs;

(b) in so far as practicable, his or her religious and cultural practices are respected;

(c) the resident's death is handled with dignity and propriety, and;

(d) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(3) The registered proprietor shall ensure that when the sudden death of a resident occurs:

(a) in so far as practicable, his or her religious and cultural practices are respected;

(b) the resident's death is handled with dignity and propriety, and;

(c) in so far as is practicable, the needs of the resident's family, next-of-kin and friends are accommodated.

(4) The registered proprietor shall ensure that the Mental Health Commission is notified in writing of the death of any resident of the approved centre, as soon as is practicable and in any event, no later than within 48 hours of the death occurring.

(5) This Regulation is without prejudice to the provisions of the Coroners Act 1962 and the Coroners (Amendment) Act 2005.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on care of the dying, which was last reviewed in October 2019. No deaths had occurred in the approved centre since the previous inspection.

The approved centre was compliant with this regulation

Regulation 15: Individual Care Plan

COMPLIANT

The registered proprietor shall ensure that each resident has an individual care plan.

[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

INSPECTION FINDINGS

The approved centre had a written policy in relation to the development, use, and review of individual care plans (ICPs), which was last reviewed in May 2020. The policy addressed requirements of the *Judgement Support Framework*, with the exception of the processes and procedures for resident access to their ICPs.

The individual care plan (ICP) was a composite set of documentation, which included allocated sections for goals, treatment, care, and resources required and allocated space for reviews. The ICP was located in the clinical file, was identifiable and uninterrupted, and was not amalgamated with progress notes. The initial care plan was completed by the multi-disciplinary team (MDT) within seven days of admission. The ICP was discussed, agreed where practicable, and drawn up with the participation of the resident and their representative, family, and next of kin.

Appropriate goals for the resident were documented within the ICP template. The ICP identified the care and treatment required to meet the goals identified, including the frequency and responsibilities for implementing care and treatment. Resources required to provide the care and treatment identified included individual or group therapies together with nutritional management. Due to COVID-19 restrictions, the resident did not attend ICP reviews; the resident met with their keyworker prior to the meeting and again afterwards to discuss and agree on the treatment plan. The ICP was updated following review, as indicated by the resident's changing needs, condition, circumstances, and goals.

The approved centre was compliant with this regulation

Regulation 16: Therapeutic Services and Programmes

COMPLIANT

(1) The registered proprietor shall ensure that each resident has access to an appropriate range of therapeutic services and programmes in accordance with his or her individual care plan.

(2) The registered proprietor shall ensure that programmes and services provided shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a resident.

INSPECTION FINDINGS

The therapeutic services and programmes provided by the approved centre were appropriate and met the assessed needs of the residents, as documented in their individual care plans. There was a comprehensive document folder with a breakdown of all the therapeutic activities and programmes in the approved centre. These included an art psychotherapy group, cognitive behavioural therapy, 1:1 dietetic education with a dietitian, Recovery Principles Group, and a Body Image Group. These were directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of residents.

Additionally, where a resident required a therapeutic service or programme that was not provided internally, the approved centre arranged for the service to be provided by an approved, qualified health professional in an appropriate location.

The approved centre was compliant with this regulation

Regulation 18: Transfer of Residents

COMPLIANT

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.

(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

INSPECTION FINDINGS

Processes: The approved centre had a written policy and procedures in relation to the transfer of residents, which was last reviewed in April 2019. Relevant staff had signed the signature log to indicate that they had read and understood the policy. Relevant staff interviewed were able to articulate the processes for the transfer of residents, as set out in the policy.

There had been no transfers from the approved centre since the last inspection.

The approved centre was compliant with this regulation

Regulation 19: General Health

COMPLIANT

(1) The registered proprietor shall ensure that:

(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;

(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;

(c) each resident has access to national screening programmes where available and applicable to the resident.

(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

INSPECTION FINDINGS

The approved centre had a medical emergencies policy, which was last reviewed in May 2020. COVID-19 limitations were taken into account relating to pre-admission gastroenterology assessment. There was evidence of the policies on the provision of general health services and responding to medical emergencies being implemented throughout the approved centre.

The approved centre had an automated external defibrillator (AED), which was located and maintained in the main staff office; an emergency tray was also available. The service utilised an emergency ambulance in the case of a medical emergency. Weekly checks were completed on the resuscitation tray and on the AED, as confirmed in a documented checklist on inspection. All admissions to the approved centre had a medical assessment undertaken and documented by a neighbouring GP practice. It was documented that residents received appropriate general health care interventions in line with individual care plans. Monitoring of physical health was documented.

The six-monthly general health assessment documented the following: physical examination; family/personal history; body mass index (BMI), weight, and waist circumference; blood pressure; smoking status; nutritional status (diet and physical activity, including sedentary lifestyle); a medication review, and; dental health.

Information was provided to residents regarding the national screening programmes available through the approved centre. There was no specific smoking cessation programme as the approved centre specialised in eating disorders.

The approved centre was compliant with this regulation

Regulation 20: Provision of Information to Residents

COMPLIANT

(1) Without prejudice to any provisions in the Act the registered proprietor shall ensure that the following information is provided to each resident in an understandable form and language:

(a) details of the resident's multi-disciplinary team;

(b) housekeeping practices, including arrangements for personal property, mealtimes, visiting times and visiting arrangements;

(c) verbal and written information on the resident's diagnosis and suitable written information relevant to the resident's diagnosis unless in the resident's psychiatrist's view the provision of such information might be prejudicial to the resident's physical or mental health, well-being or emotional condition;

(d) details of relevant advocacy and voluntary agencies;

(e) information on indications for use of all medications to be administered to the resident, including any possible side-effects.

(2) The registered proprietor shall ensure that an approved centre has written operational policies and procedures for the provision of information to residents.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the provision of information to residents, which was last reviewed in April 2020. Required information was provided to residents and/or their representative at admission, including the approved centre's information booklet that detailed the care and services. The booklet was available in the required formats to support resident needs and information was clearly and simply written. This booklet contained details of the following: housekeeping arrangements, including arrangements for personal property and mealtimes; the complaints procedure; visiting times and arrangements, and; resident rights. Residents were provided with full details of their multi-disciplinary team. Relevant advocacy and voluntary agencies were not documented, but advocacy contacts (IAN) were documented on the approved centre notice board.

Residents were provided with written and verbal information on diagnosis. Information on eating disorders and treatment was available through the approved centre. Furthermore, all residents were fully informed regarding their diagnosis and treatment. The content of medication information sheets, including information on indications for use and side-effects of all medications to be administered to the resident, was made available. Residents were also provided with their personal medication data sheets as part of the dispensing process. Residents had access to interpretation and translation services as required.

The approved centre was compliant with this regulation

Regulation 21: Privacy

COMPLIANT

The registered proprietor shall ensure that the resident's privacy and dignity is appropriately respected at all times.

INSPECTION FINDINGS

It was observed that residents were called by their preferred name. In addition, the general demeanour of staff, the manner in which staff communicated with residents, staff appearance and dress, and staff discretion when discussing the resident's condition or treatment needs were noted as in accordance with personal dignity. Additionally, both residents interviewed by the inspection team were very complimentary about how they were treated by staff and how staff engaged with them. Staff were casually but professionally dressed, and not in uniform.

All bathrooms, showers, toilets, and single bedrooms had locks on the inside of the door, unless there was an identified risk to the resident. Rooms were not overlooked by public areas and, if so, the windows had opaque glass. Noticeboards did not display resident names or other identifiable information. Furthermore, residents were facilitated to make private phone calls.

The approved centre was compliant with this regulation

Regulation 22: Premises

COMPLIANT

(1) The registered proprietor shall ensure that:

(a) premises are clean and maintained in good structural and decorative condition;

(b) premises are adequately lit, heated and ventilated;

(c) a programme of routine maintenance and renewal of the fabric and decoration of the premises is developed and implemented and records of such programme are maintained.

(2) The registered proprietor shall ensure that an approved centre has adequate and suitable furnishings having regard to the number and mix of residents in the approved centre.

(3) The registered proprietor shall ensure that the condition of the physical structure and the overall approved centre environment is developed and maintained with due regard to the specific needs of residents and patients and the safety and well-being of residents, staff and visitors.

(4) Any premises in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall be designed and developed or redeveloped specifically and solely for this purpose in so far as it practicable and in accordance with best contemporary practice.

(5) Any approved centre in which the care and treatment of persons with a mental disorder or mental illness is begun after the commencement of these regulations shall ensure that the buildings are, as far as practicable, accessible to persons with disabilities.

(6) This regulation is without prejudice to the provisions of the Building Control Act 1990, the Building Regulations 1997 and 2001, Part M of the Building Regulations 1997, the Disability Act 2005 and the Planning and Development Act 2000.

INSPECTION FINDINGS

All single rooms in the approved centre were adequately sized. There were spacious areas downstairs where residents could be alone during the day if desired. There were three appropriately sized communal rooms in the main house, and one in the garden annex also. There was suitable and sufficient heating with a minimum temperature of 18 °C (65 °F) in bedroom areas and 21 °C (70 °C) in day areas and in bedrooms. Rooms were fully ventilated, and private and communal areas were suitably sized and furnished.

The lighting in communal rooms suited the needs of residents and staff; it was sufficiently bright and positioned to facilitate reading and other activities. Furthermore, appropriate signage and sensory aids were provided to support resident orientation needs. Sufficient spaces were provided for residents to move around, including the outdoor space of the approved centre garden. Hazards, including large open spaces, steps and stairs, slippery floors, hard and sharp edges, and hard or tough surfaces, were minimised in the approved centre. Minimisation of ligature points to the lowest practicable level was evident, based on risk assessment.

The approved centre was kept in a good state of repair both internally and externally. There was a programme of general maintenance, decorative maintenance, cleaning, decontamination, and repair of assistive equipment. Records of this programme were maintained. The approved centre was clean, hygienic, and free from offensive odours. Rooms were centrally heated with pipe work and radiators guarded or guaranteed to have surface temperatures no higher than 43 °C. Additionally, current national infection control guidelines were followed.

There was a sufficient number of toilets and showers for residents in the approved centre. There was at least one assisted toilet per floor. While rooms in the approved centre varied in size, they were all appropriately sized. Additionally, the approved centre provided suitable furnishings to support resident independence and comfort.

The approved centre was compliant with this regulation

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.

(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

INSPECTION FINDINGS

The approved centre had a written policy and procedures on the ordering, prescribing, storing and administration of medicines, which was last reviewed in October 2019. It contained all necessary processes, including:

- The process for ordering resident medication.
- The process for prescribing resident medication.
- The process for storing resident medication.
- The process for the administration of resident medication, including routes of medication.

A Medication Prescription and Administration Record (MPAR) was maintained for each resident. This outlined the following: a record of any allergies or sensitivities to any medications, the administration route of medication; a record of all medications administered to the resident; a clear record of the date of discontinuation for each medication; the Medical Council Registration Number (MCRN) of every medical practitioner prescribing medication to the resident; and, the signature of the medical practitioner/nurse prescriber for each entry.

All entries in the MPAR were legible, and medication was reviewed and rewritten at least six-monthly or more frequently, where there is a significant change in the resident's care or condition. This was documented in the clinical file.

Medication was stored in the appropriate environment as indicated on the label or packaging, or as advised by the pharmacist. Where medication required refrigeration, a log of the temperature of the refrigeration storage unit was taken daily. Medication dispensed or supplied to the resident was stored securely in a locked storage unit, with the exception of medication that was recommended to be stored elsewhere.

The approved centre was compliant with this regulation

Regulation 24: Health and Safety

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the health and safety of residents, staff and visitors.

(2) This regulation is without prejudice to the provisions of Health and Safety Act 1989, the Health and Safety at Work Act 2005 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written policy and operating procedures relating to health and safety, which was last reviewed in May 2020.

The approved centre was compliant with this regulation

Regulation 26: Staffing

COMPLIANT

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.

(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.

(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.

(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.

(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.

(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to staffing, which was last reviewed in March 2020. The policy included the recruitment and selection process of the approved centre, including the Garda vetting requirements

The numbers and skill mix of staffing were sufficient to meet resident needs in the approved centre. An appropriately qualified staff member was on duty and in charge at all times; this was documented. Additionally, The Mental Health Act 2001, the associated regulations (S.I. No. 551 of 2006) and Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

As the impact of COVID-19 affected the ability of the approved centre to fulfil its regulatory requirements in relation to staff training on this inspection, Section 26(4) and 26(5) was deferred until 2021.

The following is a table of clinical staff assigned to the approved centre.

Staff in Approved Centre		
Staff Grade	**Day**	**Night**
Director of Services	1 WTE (9-5)	-
Registered Psychiatric Nurse	1	1
Occupation Therapist	-	-
Social Worker	-	-
Psychologist	1	-

In-reach to Approved Centre*		
Staff Grade	**Day**	**Night**
Consultant Psychiatrist	2 days per week	-
Non Consultant Hospital Doctor	-	-
Occupation Therapist	-	-
Social Worker	-	-
Psychologist	-	-
Dietician	Sessional	-
Psychotherapist (3)	Sessional	

Whole time equivalent (WTE)

**Staff that are not assigned to the ward or unit but visit to provide assessments, therapy, and management input.*

The approved centre was compliant with this regulation

Regulation 27: Maintenance of Records

COMPLIANT

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.

(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.

(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.

(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

Note: Actual assessment of food safety, health and safety and fire risk records is outside the scope of this Regulation, which refers only to maintenance of records pertaining to these areas.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to the maintenance of records, which was last reviewed in January 2019 and included all required aspects**.** All residents' records were secure, up to date, and in good order. They were constructed, maintained, and used in accordance with national guidelines and legislative requirements. All resident records were physically stored together. Records were reflective of the residents' status at the time of inspection and the care and treatment being provided.

Resident records were developed and maintained in a logical sequence. There were no loose pages and records were appropriately secured throughout the approved centre from loss or destruction and tampering, as well as unauthorised access or use. Records were stored in a locked room where medication was also stored. Furthermore, documentation of food safety, health and safety, and fire inspections was maintained in the approved centre.

The approved centre was compliant with this regulation

Regulation 28: Register of Residents

COMPLIANT

(1) The registered proprietor shall ensure that an up-to-date register shall be established and maintained in relation to every resident in an approved centre in a format determined by the Commission and shall make available such information to the Commission as and when requested by the Commission.

(2) The registered proprietor shall ensure that the register includes the information specified in Schedule 1 to these Regulations.

INSPECTION FINDINGS

The approved centre had a documented register of residents, which was up to date. It contained all of the required information listed in Schedule 1 to the Mental Health Act 2001 (Approved Centres) Regulations 2006.

The approved centre was compliant with this regulation

Regulation 29: Operating Policies and Procedures

COMPLIANT

The registered proprietor shall ensure that all written operational policies and procedures of an approved centre are reviewed on the recommendation of the Inspector or the Commission and at least every 3 years having due regard to any recommendations made by the Inspector or the Commission.

INSPECTION FINDINGS

All the required operating policies and procedures had been reviewed within the previous three years.

The approved centre was compliant with this regulation

Regulation 31: Complaints Procedures

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has written operational policies and procedures relating to the making, handling and investigating complaints from any person about any aspects of service, care and treatment provided in, or on behalf of an approved centre.

(2) The registered proprietor shall ensure that each resident is made aware of the complaints procedure as soon as is practicable after admission.

(3) The registered proprietor shall ensure that the complaints procedure is displayed in a prominent position in the approved centre.

(4) The registered proprietor shall ensure that a nominated person is available in an approved centre to deal with all complaints.

(5) The registered proprietor shall ensure that all complaints are investigated promptly.

(6) The registered proprietor shall ensure that the nominated person maintains a record of all complaints relating to the approved centre.

(7) The registered proprietor shall ensure that all complaints and the results of any investigations into the matters complained and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.

(8) The registered proprietor shall ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

(9) This Regulation is without prejudice to Part 9 of the Health Act 2004 and any regulations made thereunder.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures on the complaints process. The policy was last reviewed in April 2019 and included the process for managing complaints, including the raising, handling, and investigation of complaints from any person regarding aspects of the services, care, and treatment provided in or on behalf of the approved centre.

There was a nominated person responsible for dealing with all complaints who was based in the approved centre. There were details about the complaints procedure in each resident bedroom and in the patient charter in the front reception hall; the information was also provided within the resident information booklet. The complaints procedure and information on how to contact the nominated person was publicly displayed. Residents, their representatives, family, and next of kin were informed of all methods by which a complaint could be made.

All complaints, whether written or oral, were investigated promptly and handled appropriately and sensitively. Additionally, the registered proprietor ensured that the quality of the service, care, and treatment of a resident was not adversely affected by reason of a complaint being made. Minor complaints were documented in the community minutes where applicable, though none had been made since the last inspection. All complaints that were not minor were dealt with by the nominated person and recorded in the complaints log. No minor complaints had been made outside of community meetings. Details of complaints, as well as subsequent investigations and outcomes, were fully recorded and kept distinct from the residents' individual care plan. Furthermore, the complainant was informed promptly of the outcome of the complaint investigation and details of the appeals process being made available to them; this was documented.

The approved centre was compliant with this regulation

Regulation 32: Risk Management Procedures

COMPLIANT

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.

(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:

(a) The identification and assessment of risks throughout the approved centre;

(b) The precautions in place to control the risks identified;

(c) The precautions in place to control the following specified risks:

(i) resident absent without leave,

(ii) suicide and self harm,

(iii) assault,

(iv) accidental injury to residents or staff;

(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;

(e) Arrangements for responding to emergencies;

(f) Arrangements for the protection of children and vulnerable adults from abuse.

(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

INSPECTION FINDINGS

The approved centre had a written operational policy and procedures in relation to risk management, which was last reviewed and dated August 2018. The risk management policy addressed all requirements.

There was evidence of the risk management policy being implemented throughout the approved centre. This included, but not limited to, the following: responsibilities were allocated at management level and throughout the approved centre to ensure their effective implementation; the person with responsibility for risk was identified and known by all staff; and, the risk management procedures actively reduced identified risks to the lowest practicable level of risk. Clinical risks, health and safety risks, and corporate risks were identified, assessed, treated, reported, and monitored, and documented in the risk register as appropriate. Structural risks, including ligature points, were removed or effectively mitigated.

Individual risk assessments were completed prior to and during the following: at admission to identify individual risk factors, including general health risks, risk of absconding or self-harm; resident discharge; and, in conjunction with medication requirements or administration. Multi-disciplinary teams were involved in the development, implementation, and review of individual risk management processes. Residents and their representatives were involved in individual risk management processes. Furthermore, the requirements for the protection of children and vulnerable adults within the approved centre were appropriate and implemented as required.

Incidents were recorded and risk-rated in a standardised format utilising the services' template when required. Two incidents had occurred since the last inspection, and they were reviewed by the multi-

disciplinary team at their regular meeting. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the service. Also, the approved centre provided a six-monthly summary report of all incidents to the Mental Health Commission in line with the Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Information provided was anonymous at resident level. There was an emergency plan that specified responses by approved centre staff to possible emergencies. In this respect, the emergency plan incorporated evacuation procedures.

The approved centre was compliant with this regulation

Regulation 33: Insurance

COMPLIANT

The registered proprietor of an approved centre shall ensure that the unit is adequately insured against accidents or injury to residents.

INSPECTION FINDINGS

The approved centre's insurance certificate was provided to the inspection team. It confirmed that the approved centre was covered for public liability, employer's liability, clinical indemnity, and property.

The approved centre was compliant with this regulation

Regulation 34: Certificate of Registration

COMPLIANT

The registered proprietor shall ensure that the approved centre's current certificate of registration issued pursuant to Section 64(3)(c) of the Act is displayed in a prominent position in the approved centre.

INSPECTION FINDINGS

The approved centre had an up-to-date certificate of registration. The certificate was displayed prominently in the outer hall area of the approved centre and included the conditions currently applicable within the approved centre.

The approved centre was compliant with this regulation

8.0 Inspection Findings – Rules

EVIDENCE OF COMPLIANCE WITH RULES UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

None of the rules under Mental Health Act 2001 Section 52(d) were applicable to this approved centre. Please see *Section 4.3 Areas of compliance that were not applicable on this inspection* for details.

9.0 Inspection Findings – Mental Health Act 2001

EVIDENCE OF COMPLIANCE WITH PART 4 OF THE MENTAL HEALTH ACT 2001

10.0 Inspection Findings – Codes of Practice

EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

Section 33(3)(e) of the Mental Health Act 2001 requires the Commission to: "prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services".

The Mental Health Act, 2001 ("the Act") does not impose a legal duty on persons working in the mental health services to comply with codes of practice, except where a legal provision from primary legislation, regulations or rules is directly referred to in the code. Best practice however requires that codes of practice be followed to ensure that the Act is implemented consistently by persons working in the mental health services. A failure to implement or follow this Code could be referred to during the course of legal proceedings.

Admission, Transfer and Discharge

COMPLIANT

Please refer to the Mental Health Commission Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, for further guidance for compliance in relation to this practice.

INSPECTION FINDINGS

Processes: The approved centre had a policy in relation to admission, transfer, and discharge.

Admission: The admission policy, which was last reviewed in April 2019, included all the policy-related criteria for this code of practice.

Transfer: The transfer policy, which was last reviewed in April 2019, included all the policy-related criteria for this code of practice.

Discharge: The discharge policy, which was last reviewed in April 2019, included all the policy-related criteria for this code of practice.

Training and Education: There was documentary evidence that relevant staff had read and understood the admission, transfer, and discharge policy.

Monitoring: Audits had been completed on the implementation of and adherence to the admission, transfer, and discharge policy.

Evidence of Implementation:

Admission: A key worker system was in place, and admission was on the basis of mental illness or a mental disorder. An admission assessment was also completed, which included but was not limited to: presenting problem; past psychiatric history; and, medical history. Resident's family member/carer/advocate was involved in the admission process, with the residents consent.

Transfer: The approved centre complied with Regulation 18: Transfer of Residents.

Discharge: The discharge plan included the estimated date of discharge, a follow-up plan, and a reference to early warning signs of relapse and risks. The discharge meeting was attended by the resident, key worker, relevant members of the multi-disciplinary team, and family, carer, or advocate, where appropriate and with the consent of the resident.

The discharge assessment included the following: psychiatric and psychological needs; current mental state examination; and, informational needs. The discharge was coordinated by the key worker, and preliminary the discharge summary was sent to the general practitioner, primary care, or community mental health team (CMHT) within 14 days. A comprehensive discharge summary was issued within 14 days.

Discharge summaries included the following: diagnosis; prognosis; and, medication. The family member, carer, or advocate was involved in the discharge process, where appropriate. The discharge summary also included a timely follow up appointment, which was within one week where there was a recent history of self-harm or a suicide risk.

The approved centre was compliant with this code of practice.

Appendix 1 Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

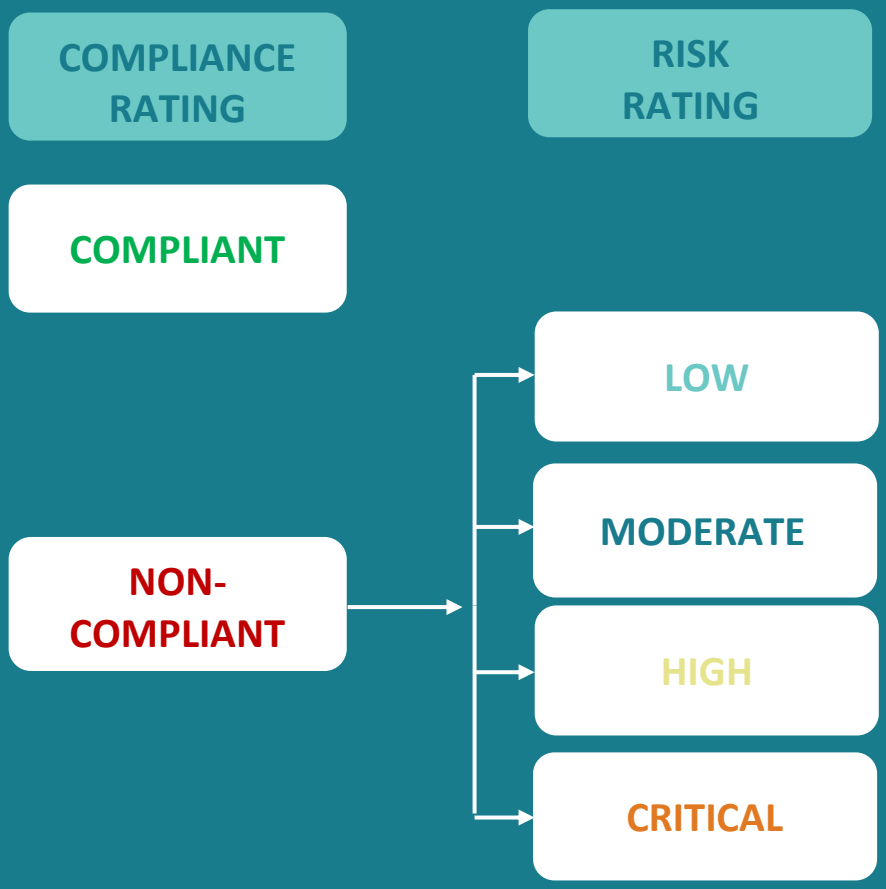
Each approved centre will be assessed against all regulations, rules, codes of practice, and Part 4 of the 2001 Act as applicable, at least once on an annual basis. Inspectors will use the triangulation process of documentation review, observation and interview to assess compliance with the requirements. Where non-compliance is determined, the risk level of the non-compliance will be assessed.

Following the inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings, risk ratings and quality assessments, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

COMPLIANCE AND RISK RATINGS

The following ratings are assigned to areas inspected:

COMPLIANCE RATINGS are given for all areas inspected.
RISK RATINGS are given for any area that is deemed non-compliant.



The registered proprietor is given an opportunity to review the draft report and comment on any of the content or findings. The Inspector will take into account the comments by the registered proprietor and amend the report as appropriate.

The registered proprietor is requested to provide a Corrective and Preventative Action (CAPA) plan for each finding of non-compliance in the draft report. Corrective actions address the specific non-compliance(s). Preventative actions mitigate the risk of the non-compliance reoccurring. CAPAs must be specific, measurable, achievable, realistic, and time-bound (SMART). The approved centre's CAPAs are included in the published inspection report, as submitted. The Commission monitors the implementation of the CAPAs on an ongoing basis and requests further information and action as necessary.

If at any point the Commission determines that the approved centre's plan to address an area of non-compliance is unacceptable, enforcement action may be taken.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.